# STATE OF TENNESSEE

# WORKERS' COMPENSATION ADVISORY COUNCIL

~~~~~~~~~~~~~~~~

***ANALYSIS & COMMENTS***

***re:***

***AMENDMENTS TO WORKERS' COMPENSATION LEGISLATION***

~~~~~~~~~~~~~~~~

# WORKERS' COMPENSATION ADVISORY COUNCIL

~~~~~~~~~~~~~~~~

## *ANALYSIS & COMMENTS*

~

***PROPOSED AMENDMENTS***

***2007 WORKERS' COMPENSATION LEGISLATION***

~~~~~~~~~~~~~~~~

**TABLE OF CONTENTS**

## NUMERICAL INDEX OF AMENDED SENATE BILLS



## NUMERICAL INDEX OF HOUSE BILLS

# TABLE OF AMENDED BILLS
(BY SUBJECT MATTER)

NOTE: The description of the bill and amendment in the following table is a limited description and does not describe all aspects of the bill or the amendment.

| **COVERAGE** | **SB#** | **Sponsor** | **HB#** | **Sponsor** | **DESCRIPTION** |
|---|---|---|---|---|---|
| | 1748<br>pp7-8 | Ketron | 1645 | Mumpower | ORIGINAL BILL: Requires sole proprietors and partners to carry workers compensation insurance on themselves<br>**AMENDMENT**: Requires all persons in construction to carry work comp insurance - exempts homeowners who perform own work and those who perform home repairs for homeowner for less than $5000 |
| **MEDICAL FEE SCHEDULE** | **SB#** | **Sponsor** | **HB#** | **Sponsor** | **DESCRIPTION** |
| | 445<br>pp9-11 | Burchett | 454 | Hackworth | ORIGINAL BILL: Prohibits negotiated commercial health insurance contracts to be applied in workers' compensation.<br>**AMENDMENT:** Requires signed contract between provider and insurer, employer, pool or network administrator and prohibits assignment of contract |
| | 496<br>pp12-13 | Burchett | 1603 | Overbey | ORIGINAL BILL: Requires Comm'r of Labor/WFD to promulgate rules to establish civil penalty against provider found to have fraudulently billed and collected amount in excess of the medical fee schedule<br>**AMENDMENT**: Requires payor to notify provider of overpayment - give reasonable time to comply and to exhaust all appeals prior to penalty to provider; prohibits penalty for pattern or practice unless notice, exhaustion of appeals and 90 days have expired |

| | | | | | |
|---|---|---|---|---|---|
| | 1474<br>pp14-16 | McNally | 1518 | Hackworth | ORIGINAL BILL: pertained to protecting all approved providers from liability for releasing medical records<br>**AMENDMENT**: Amendment prohibits 2 tier reimbursement under medical fee schedule for physical therapy - doctor owned facilities vs. independent facilities |
| **WORKERS' COMPENSATION BENEFITS** | **SB#** | **Sponsor** | **HB#** | **Sponsor** | **DESCRIPTION** |
| | 322<br>pp17-18 | Haynes | 1818 | Hackworth | ORIGINAL BILL: Permits Comm'r of Labor/WFD or designee to order work comp benefits paid equally by 2 carriers (self-insureds) when claim is compensable and there is dispute as to had coverage<br>**AMENDMENT**: provides the 2 carriers shall equally pay loss adjusting expenses pertaining to claim; extends life of Joint Committee until June 30, 2012 |
| | 425<br>p19 | Crutchfield | 1822 | Buck | ORIGINAL BILL: Prohibits social security offset from applying to death benefits; requires copies of all information available to specialist related to request for assistance to be provided to the parties<br>**AMENDMENT**: revises bill to require the parties who submit documents or records, etc to supply copy to opposing party; provides opportunity to review specialist's file and right to request copy of file; provides copying fee of $10.00 first 25 pages; 25cents each page thereafter. |
| | 1775<br>pp20-22 | Southerland | 2128 | Fitzhugh | ORIGINAL BILL: Multiplier caps applicability to be measured by whether employee returned to work at any job at same/equal pay<br>**AMENDMENT**: prohibits receipt of TTD benefits if received unemployment benefits; applies penalty for non-attendance at mediation to employee in addition to employer/insurer |

| | | | | | |
|---|---|---|---|---|---|
| | 1797 pp23-25 | Southerland | 2129 | Fitzhugh | ORIGINAL BILL:<br>>Changes 2004 act language related to inability of employee to settle issue of future medicals-will permit court or dept to permit settlement if "in best interests of all parties to do so";<br>>Adds definition of "repetitive injury" -<br>>For repetitive injuries burden of proof changed to clear and convincing evidence instead of preponderance of evidence<br>**AMENDMENT**: permits employees to settle right to future medical benefits |
| **WORKERS' COMPENSATION ADVISORY COUNCIL** | **SB#** | **Sponsor** | **HB#** | **Sponsor** | **DESCRIPTION** |
| | 1043 p26 | Finney, L | 595 | Turner, M | ORIGINAL BILL: Makes chairs (or co-chairs) of standing committees ex officio members of Advisory Council; deletes chair/co-chair of Joint Committee as ex officio members<br>**AMENDMENT**: The amendment is a technical correction - changes word "co-chair" to "vice-chair". |
| **ADDENDUM late amendment** | **SB#** | **Sponsor** | **HB#** | **Sponsor** | **DESCRIPTION** |
| | 1805 pp27-28 | Tracey | 1569 | Curtiss | ORIGINAL BILL: Section 3 revises the MIRR program<br>**AMENDMENT**: The amendment deletes Section 2 of the original bill. |

**AMENDED SB 1748 by Ketron / HB 1645 by Mumpower**

The amendment re-writes the original bill.

***Present Law***

*TCA* §50-6-113(f)(1) requires any person who is engaged in the construction industry (principal contractors, intermediate contractors, or subcontractors) to carry workers' compensation insurance even if they have fewer than 5 employees. The section does exempt sole proprietors, partners and those who builds a dwelling or structure for personal on the person's own property from the requirement to carry workers' compensation coverage.

*TCA* §50-6-113(f)(4) exempts counties with a 1990 census of 6,700 - 6,950 and 44,500 - 45,000 from the application of subsection (f).

***Proposed Amendatory Change***

Section 1 of the amendment:

- requires all persons engaged in the construction industry - whether or not the person employs fewer than 5 employees to carry workers' compensation insurance;
- continues the exemption for a person who builds a dwelling or makes additions to his/her own property; and
- creates an exemption from the workers' compensation insurance requirement for any sole proprietor or partner who performs maintenance, repairs, improvements - or who makes additions to structures, on a residential dwelling for the homeowner for which the total compensation for the job/project - including labor and materials - is less than $5,000.00

Section 2 of the amendment deletes the section of the statute that exempts the specified counties whose 1990 census is set out in the original statute.

***Practical Effect of Amendment***

The amendment requires every person engaged in the construction industry - including principal contractors, intermediate contractors, subcontractors, sole proprietors and partners - to carry workers' compensation insurance EXCEPT those persons who build or repair their own property for

**AMENDED SB 1748 by Ketron / HB 1645 by Mumpower, cont.**

their own use and those persons who perform home repairs/improvements to a residential dwelling for the owner of the dwelling - provided the total cost of the labor and materials is less than $5,000.

***COMMENTS OF ADVISORY COUNCIL MEMBERS:***

The members of the Council are supportive of the concept to require any person in the construction industry to have workers' compensation insurance. They believe the amendment is a good policy that moves the state toward a better system in terms of coverage and provides more clarity as to who is required to have workers compensation coverage and who is not.

The members of the Council have concerns related to the language in Section 1(b) of the proposed amendment (the exemption for any sole proprietor or partner who performs maintenance, repair or improvements on a residential dwelling provided the total cost is less than $5000). Although the members understand the intent of the supporters of the amendatory language is that the exemption applies only when there is a direct agreement or contract between the sole proprietor/partner and the homeowner, Section 1(b) does not include such language.

The voting members suggest Section 1(b) could potentially be improved by clarifying the intent of the provision is that there be a direct relationship, direct contract or direct agreement between the sole proprietor/partner and the homeowner to eliminate the possibility of a person trying to defeat the purpose of the exemption if the language of Section1(b) is left unchanged.

**AMENDED SB 445 by Burchett / HB 454 by Hackworth**

***Present Law***

*TCA* §50-6-204(i), enacted in 2004, authorized the Commissioner of Labor/WFD to establish a Medical Fee Schedule. The Medical Fee Schedule has been in effect since July 1, 2005. A medical care provider cannot charge more than the Medical Fee Schedule and the employer/insurer is not permitted to pay more than the Medical Fee Schedule authorized charge. Subdivision *TCA* §50-6-204(i)(7) specifically permits an employer, trust or pool, or insurer to negotiate reimbursement fees lower than the medical fee schedule.

***Proposed Amendatory Change***

The amendment adds language at the end of *TCA* §50-6-204(i)(7). The new language applies to fees paid for medical fees provided on or after **January 1, 2008** and:

- prohibits payments for medical services to be less than the medical fee schedule UNLESS there is a contract or agreement negotiated and signed directly between the healthcare provider and the employer, trust, pool or insurer or network administrator;

  The amendment defines "network administrator" as an "entity that may be a business or an agent operating on behalf of an employer, trust, pool or insurer that holds a direct contract or agreement negotiated and signed with the health care provider for access to workers' compensation treatment offering negotiated savings at or below the "comprehensive medical fee schedule".
- prohibits assignment of - or access to - the negotiated rates for workers' compensation services to any party other than the employer, trust, pool, insurer or network provider who signed the contract or agreement;
- prohibits assignment of - or access to - the rates negotiated by a network administrator (who has a contract with an employer to manage its workers' compensation program) to any other network administrator;
- requires any company marketing itself as a "network administrator" to be able to produce - upon request of a health care provider - a signed workers' compensation product contract between the "network administrator" and the medical provider. If a contract or agreement does not exist then the provider is to be paid the amount authorized by the medical fee schedule

**AMENDED SB 445 by Burchett / HB 454 by Hackworth, cont.**

***Proposed Amendatory Change, continued***

- prohibits application of a contract/agreement negotiated on a commercial health insurance product to payments for workers' compensation services provided by the health care provider UNLESS the contract/agreement clearly and expressly permits such rates to be applied to workers' compensation services.

***Practical Effect of Amendment***

This amendment makes it clear that in order for a health care provider to be paid less than the amount set out in the medical fee schedule there must be a contract directly between the health care provider and the employer, pool or trust, insurer or network administrator. The amendment specifically prohibits an entity who has a contract with a health care provider from selling or assigning the negotiated fees to another entity. Finally, the amendment clarifies those instances in which negotiated fees in commercial health insurance can be applied to workers' compensation services by requiring a contract that specifically permits such application.

***Informational Note***

Anecdotal evidence indicates there are insurance companies or network administrators have been "selling" their contractual fee agreements to third parties without the knowledge and consent of the health care provider. The third party (could be another insurance company, a pool, or another network administrator) purchases from the original company or network administrator the right to use their negotiated networks, without the knowledge of the provider. Then, the health care provider receives a reimbursement amount from this third party that is less than the fee schedule and the provider cannot figure out how the amount was calculated when the provider has never entered into a contract with this third party.

In addition, there have been reports of fees paid for workers' compensation services at the rates negotiated in contracts pertaining to the general health insurance arena although no contract to do so exists with the provider.

**AMENDED SB 445 by Burchett / HB 454 by Hackworth, cont.**

***COMMENTS OF ADVISORY COUNCIL MEMBERS:***

**EMPLOYER REPRESENTATIVES:**

Mr. Bob Pitts — Mr. Pitts stated he had two concerns about the amendment as drafted:

1. The language that prohibits the negotiated rates from being "accessible to" any party other than the one that has a direct contract with the provider could prohibit an employer, trust/pool or someone from simply learning what the negotiated rates are.
2. The amendment, as drafted, would appear to prevent an owner (or estate of the owner) of a company that functions as a "network administrator" and has direct contracts with providers for discounted rates from selling the business to another person or entity because the provider contracts could not be assigned to the new owner.

**ATTORNEY REPRESENTATIVES:**

Mr. Tony Farmer — Mr. Farmer stated he thinks this amendment will solve the problem that has arisen in East Tennessee where providers are receiving payments at a discounted rate from an entity with which there is no agreement to accept a payment less than the medical fee schedule.

**INSURANCE COMPANY REPRESENTATIVE:**

Mr. Jerry Mayo — Mr. Mayo had concerns that the proposed amendment will hurt small self-insured employers who are not large enough to negotiate their network of providers who will agree to accept payments less than the medical fee schedule. He stated he needs more time to analyze the language of the amendment to determine whether the insurance industry can support the amendment.

**AMENDED SB 496 by Burchett / HB 1603 by Overbey**

***Present Law***

*TCA* §50-6-233 is the statute that outlines the power of the Commissioner of Labor/WFD to enforce the provisions of the workers' compensation law. Subdivision (c)(8) requires the Commissioner's rules and regulations to establish a civil penalty, assessed at the discretion of the Commissioner, against a health care provider who refuses to repay payor (insurer/employer/TPA) for payments made in excess of the rates set by the Medical Fee Schedule. The law also states that no provider is to be assessed a penalty solely for receiving a payment in excess of the Medical Fee Schedule.

To understand the amendatory language, one must read subdivision (c)(8) with the phrase that precedes the list of eight (8) items in the subdivision. The phrase is: "The commissioner's rules and regulations shall include, but not be limited to, the rules and regulations: (1).....(8) "To establish a civil penalty...".

The pertinent rule promulgated by the Department is 0800-2-18-.15 "Penalties For Violations of Fee Schedules". The rule states that no provider shall accept and no employer/carrier shall pay an amount for health care services in excess of the maximum permitted by the medical fee schedule. The provider or payor has 90 days from receipt or payment to correct the error without there being a violation of the rules. Further, a monetary penalty cannot be assessed unless a "pattern or practice of such activity" is found.

***Proposed Amendatory Change***

The amendment re-writes *TCA* §50-6-233(c)(8).

The amendment permits the commissioner to establish a civil penalty against a provider who has been found to have collected from a payor an amount in excess of the medical fee schedule **AFTER** the following occurs:

1. after proper notification from a payor AND
2. after an appropriate time to respond AND
3. after exhausting all appeals.

**AMENDED SB 496 by Burchett / HB 1603 by Overbey, cont.**

***Proposed Amendatory Change, continued***

The amendment prohibits imposition of a civil penalty for a pattern or practice of a provider accepting and retaining an amount in excess of the medical fee schedule UNLESS the payor shows the Department that it notified the provider of each overpayment and the provider- after exhausting all appeals - refused to refund the overpayment within 90 days. In addition, the amendatory language prohibits assessing a civil penalty solely for receiving a payment in excess of the medical fee schedule.

***Practical Effect***

The amendment nullifies the rules adopted by the Department related to penalties for violating the medical fee schedule. The amendment requires the payor to (1) notify the health care provider of the overpayment, (2) give them an "appropriate" time to respond and (3) exhaust all appeals before any civil penalty can be assessed by the commissioner.

Neither the amendment nor any other statute or rule defines what is to be considered an "appropriate" time for the response to be made by a provider to a payor who notifies the provider of an overpayment. In addition, there are no statutes or rules that create a right to appeal any issue associated with a payor's payments made in excess of the fee schedule.

Therefore, practically speaking, it will be impossible for any payor to meet the criteria set out in the amendment. Thus, it appears the commissioner could never penalize a provider for violating the medical fee schedule.

***COMMENTS OF ADVISORY COUNCIL MEMBERS:***

After an opportunity to hear from representatives of the Tennessee Hospital Association and the Administrator of the Division of Workers' Compensation and after further discussion of the amendment, the Advisory Council members unanimously urge the sponsors to consider an amendment to SB496/HB1603 that provide that no penalty will be assessed for pattern or practice for any acts occurring before July 1, 2008. This would give the interested parties an opportunity to think through the bigger issue of whether there is a need to penalize at both the provider and payor level.

**AMENDED SB 1474 by McNally / HB 1518 by Hackworth**

**NOTE**: The amendment re-writes the entire bill and the amendment addresses a subject that is entirely different from the subject matter of the original bill. The caption of the original bill opened all of Title 50, Chapter 6.

***Present Law***

*TCA* §50-6-204(i)(1) is the first subdivision that requires the Commissioner of Labor/WFD to establish a comprehensive medical fee schedule. The final sentence of the subdivision states: "The commissioner may consider any and all reimbursement systems and methodologies in developing the fee schedule."

***Proposed Amendatory Change***

The amendment adds language to the last sentence of *TCA* §50-6-204(i)(1) and includes additional language thereafter. It prohibits the use of differing rates for reimbursement or conversion factors for reimbursement of physical or occupational therapy services in the medical fee schedule based on whether the services are performed at an independently-owned facility or at a physician-affiliated facility and prohibits consideration of physician ownership in the facility providing the services. Differing reimbursement rates are permitted in the event of over-utilization of physical/occupational therapy services demonstrated by report of the commissioner to the Medical Care and Cost Containment Committee, the Advisory Council and the Joint Committee. The report must be based on information gathered by the utilization review program and must demonstrate that a bifurcated reimbursement system will correct the over-utilization of physical/occupational therapy services.

***Practical Effect***

The bill alters the current medical fee schedule which does have a bifurcated reimbursement system dependent on whether the physical/occupational therapy is provided by an independent facility or a physician affiliated facility. The reimbursement rate is less for services provided by a physician affiliated facility than the rates provided to the entity that is not associated or affiliated with a physician. The amendment does provide a mechanism where a bifurcated reimbursement system can be implemented if over-utilization occurs in one type facility.

**AMENDED SB 1474 by McNally / HB 1518 by Hackworth, cont.**

***COMMENTS OF ADVISORY COUNCIL MEMBERS:***

Mr. Dale Sims, Chair, questioned how passage of the amendment to eliminate the bifurcated payment system for physical therapy and occupational therapy will affect the amount of reimbursement for all providers of these services. Whether it will result in an increase in reimbursement rates or a decrease in reimbursement rates will depend on the actions the Department of Labor will take to amend the medical fee schedule to set a new reimbursement rate. Either way, it will have a fiscal impact on local and state governments.

The members of the Advisory Council observed that if the amendment passes as drafted, it would preclude the Department of Labor/WFD from determining if there is overutilization of physical therapy/occupational therapy in the workers' compensation arena regardless of the ownership of the OT/PT entity.

**EMPLOYER REPRESENTATIVES:**

Mr. Bob Pitts — Mr. Pitts suggested the sponsors consider changing the effective date from "immediately on passage" to a specific date in the future to permit the Department sufficient time to promulgate rules implementing the change.

Mr. Pitts observed the amendment authorizes a bifurcated system only if the Department shows such a system will control overutilization. As drafted, it precludes the Department from adopting a bifurcated system to see if it could control overutilization regardless of ownership of the facility.

**ATTORNEY REPRESENTATIVES:**

Ms. Kitty Boyte — Ms. Boyte suggested the rule that limits the number of PT/OT visits an employee should resolve overutilization issues. She observed that a treating doctor probably has more confidence in the expertise of physical therapists over whom s/he has control.

**AMENDED SB 1474 by McNally / HB 1518 by Hackworth, cont.**

***COMMENTS OF ADVISORY COUNCIL MEMBERS, continued:***

**EX OFFICIO MEMBERS**

Ms. Sue Ann Head — Ms. Head, the Administrator of the Division of Workers' Compensation, noted the Department adopted the bifurcated system of payment based on data from the Workers' Compensation Research Institute and the National Council on Compensation Insurers. The Department is in the process of obtaining medical data from insurance companies that will provide more detailed information from which to evaluate the bifurcated system and overutilization. Until they have finished the collection and analysis of the data necessary to make a determination as to the effectiveness of the bifurcated system, they do not favor the bill.

**AMENDED SB 322 by Haynes / HB 1818 by Hackworth**

***Present Law***

There is currently no provision in the Tennessee Workers' Compensation law that requires disputing carriers to pay equally the benefits to the employee and resolve the question of who had coverage at the end of the claim.

*TCA* §50-6-130(e) provides the Special Joint Committee on Workers' Compensation terminates on June 30, 2007.

***Proposed Amendatory Change***

During the Advisory Council's discussion of this bill at the March 16 meeting, it was suggested by Mr. Mayo that the two carriers should equally pay the loss adjustment expenses associated with the claim. The first amendment does add this to the bill.

The second amendment extends the Joint Committee for an additional five (5) years.

***Practical Effect***

In those instances where the Commissioner orders two carriers/self-insured employers to pay benefits to an injured employee, the Commissioner is authorized to require them to equally pay any expenses associated with the claim.

The Joint Committee would cease to exist as of June 30 this year without the amendment that extends the Committee for five (5) years.

***COMMENTS OF ADVISORY COUNCIL MEMBERS:***

The members of the Council had no comments concerning the specific amendments presented by the sponsors. However, they did have additional comments concerning the issue addressed by the main bill.

**AMENDED SB 322 by Haynes / HB 1818 by Hackworth, cont.**

***COMMENTS OF ADVISORY COUNCIL MEMBERS, continued:***

**EMPLOYEE REPRESENTATIVES:**

Mr. Jerry Lee — Mr. Lee stated anything that can be done to expedite payment to injured employees must be done because the employee can be harmed substantially to wait a long period of time to receive benefits until the issue of which carrier is responsible is resolved. A large payment two years later does not help the employee financially after they have lost their house, etc.

**ATTORNEY REPRESENTATIVES:**

Ms. Kitty Boyte — Ms. Boyte stated she understands the bill is trying to address the problem when an employee finds himself in a Catch 22 of which carrier has coverage. She noted, however, the issue is going to become a real quagmire in more types of cases given the present state of case law as to when the date of injury occurred, especially in gradual injuries situations. The Supreme Court has issued inconsistent decisions concerning when the date of injury occurs in gradual injury cases [when the injury first mentions the problems; when the employee first filled out a report; when the employee first misses work irrespective of when the report is filled out]. She suggested it may be a bad time to try to require carriers to share coverage because there will probably be more cases than expected.

Mr. Tony Farmer — Mr. Farmer suggested the two insurance carriers are in a better position to bear the financial burden of waiting until the issues are resolved than the injured worker who is not able to work.

**INSURANCE COMPANY REPRESENTATIVE:**

Mr. Jerry Mayo — Mr. Mayo suggested the bill should address which carrier is going to actually adjust the claim in addition to addressing the sharing of expenses.

**AMENDED SB 425 by Crutchfield / HB 1822 by Buck**

***Present Law***

The operating procedures of the Division of Workers' Compensation prohibit the parties from discovering the documents provided by the other party to a workers' compensation specialist in those instance where assistance is being sought regarding medical or temporary benefits.

***Proposed Change***

The original bill requires copies of all information available to a workers' compensation specialist (when considering medical or temporary disability benefits) to be provided to all parties, upon request. The amendment applies only to Section 2 of the bill and provides:

- the party supplying documents, information, etc. to a specialist must provide the other party with copies of the documents, etc. at the time they are sent to the specialist
- upon request, a party may review the specialist's file and request copies of any document or record contained in the department's file
- the department may charge for copies at the rate of $10 for pages 1 - 25 and at the rate of 25 cents per page after 25. If the request is for copies of audio tapes, video tapes or x-rays, the specialist is granted authority to require the party to provide a copy to the requesting party.

***Practical Effect***

It appears the intent of the amendment is to reduce the cost to the department for providing copies of the records, as required by the original bill. The amendment puts the burden on the producing party to supply copies to the other party and if there is something that is to be copied by the department, the amendment sets the reimbursement rate at the same rate for copying medical records as contained in *TCA* §50-6-204(a)(1).

***COMMENTS OF ADVISORY COUNCIL MEMBERS:***

**ATTORNEY REPRESENTATIVES:**

Mr. Tony Farmer — Mr. Farmer said the intent of the amendment is to relieve the department of the financial concerns with the bill.

**EX OFFICIO MEMBERS**

Ms. Sue Ann Head — Ms. Head said the Department is fine with the amendment.

**AMENDED SB 1775 by Southerland / HB 2128 by Fitzhugh**

***Present Law***

There is no current law in the workers' compensation statutes that address the issue of receipt of unemployment benefits and temporary total disability benefits for the same period of time.
**Note: During the discussion of this issue, it was suggested there are policies and/or laws or rules/regulations of the Employment Security Division of the Department of Labor/WFD that address this issue. Ms. Head agreed to make an inquiry on the issue and report the results to the Executive Director. She was unable to obtain an answer by the close of business on Friday, April 20 following the Advisory Council meeting. Therefore, the Executive Director will report on the issue at the time the bills/amendments are discussed in Committee.**

*TCA* §50-6-237(c) requires both the employee and the employer (or insurer) to provide a person at a benefit review conference who has the authority to settle the dispute. Failure by an employer or insurer to provide such a person at the conference shall subject the employer/insurer to a penalty of not less than $50.00 and not more than $5000.
**Note: During the discussion of this issue, Ms. Teresa Bullington, Director of Benefit Review Program, explained the 2004 Reform Act provides if an employee does not appear for a benefit review conference (mediation), the Commissioner may dismiss the employee's claim. The statute does provide a "safety net" if the employee contacts the Department and attends a benefit review conference within 60 days following the order of dismissal. She notes this is already a significant penalty for an employee who fails to appear (and therefore does not provide someone with authority to settle the claim). This penalty is codified in TCA §50-6-203(f).**

***Proposed Amendatory Change***

The amendment re-writes the entire bill.

Section 1 of the Amendment provides that an employee who has received unemployment benefits shall not be entitled to receive temporary total disability benefits for the same weeks for which the unemployment benefits were paid.

Section 2 of the Amendment subjects both the employee, employer and insurer to the monetary penalty if a person with authority to settle the dispute is not at the conference.

**AMENDED SB 1775 by Southerland / HB 2128 by Fitzhugh, cont.**

***Practical Effect***

**Note: The practical effect of Section 1 may be different depending on identification of current policy/rules of the Employment Security Division.**

Section 1 will prohibit an injured worker from receiving temporary total disability benefits if the employee has been laid off from the employer or the employer has gone out of business and the employee (1) has been released to return to work with restrictions the employer could not accommodate, or (2) the employee has not reached maximum medical improvement or (3) the employee has not been released to return to full duty. Under present law, an employee who has neither returned to work nor reached maximum medical improvement, would be paid temporary total disability benefits (66 2/3 of the average weekly wage - subject to the maximum weekly rate of $750 (110% of State's Average Weekly Wage which for July 1, 2006 through June 30, 2007 is $682.00).

According to the Department's "Employment Security" website, in order to receive unemployment insurance benefits, you must be unemployed through no fault of your own; you must be able and available to work; you must look for work in your usual manner and you may be required to register for work. *TCA* §50-7-303 provides that a claimant is disqualified for benefits for any week with respect to which s/he is or has received compensation for temporary partial disability under the workers' compensation law.

Section 2 will apply the penalty for not appearing at the benefit review conference (mediation) to the employee. The amendment may be directed at situations where the employee is not represented by an attorney, the employer has requested the mediation and the employee fails to appear. The amendment will not alter the specialist's current ability to exercise judgment as to whether the parties' actions (related to authority to settle) support a referral for a hearing to determine whether a penalty should be assessed.

***Informational Note***

According to the "Comparison of State Unemployment Laws" published by the U.S. Department of Labor (as of January 1, 2003) "(n)early half of the states list workers' compensation ... as disqualifying income. Some disqualify for the week concerned; others consider workers' compensation deductible income and reduce unemployment benefits by the amount of the workers' compensation payments. A few states reduce the unemployment benefit only if the workers' compensation payment is for temporary partial disability, the type of workers' compensation payment that a worker most likely could receive while certifying ability to work."

**AMENDED SB 1775 by Southerland / HB 2128 by Fitzhugh, cont.**

***Informational Note, continued***

Tennessee is in the latter category. In Connecticut, any person who has drawn unemployment compensation benefits and who subsequently receives compensation for temporary disability under a workers' compensation law with respect to the same period is required to repay the unemployment compensation benefits, provided the amount to be repaid does not exceed the amount of temporary disability benefits.

***COMMENTS OF ADVISORY COUNCIL MEMBERS:***

***SECTION 1 (Unemployment Benefits & TTD Benefits)**

**ATTORNEY REPRESENTATIVES:**

Mr. Tony Farmer — Mr. Farmer said the Department requires an employee to agree to notify the Department [Employment Security Division] if they are later compensated for the same period they received unemployment benefits and requires them to pay back the unemployment benefits.

He said the amendment is unnecessary because the Department already requires the employee to pay back unemployment benefits received if they subsequently receive workers' compensation benefits for the same period. Passage of the amendment will cause a direct conflict with the rules of the Department regarding repayment of unemployment benefits. It creates a real hardship on an employee.

***SECTION 2 (Penalty For No One With Authority At BRC)**

The members of the Advisory Council are unsure of the intent of the amendment. It was noted the current statutory language concerning a possible penalty does not apply to the employee who "fails to provide a person with authority to settle". It is assumed the intent is to apply equity and make the possibility of a penalty applicable to all parties to the benefit review conference.

**AMENDED SB 1797 by Southerland / HB 2129 by Fitzhugh**

***Present Law***

*TCA* §50-6-206(a)(2), enacted by the 2004 Reform Act, prohibits the settlement of future medical benefits for a period of 3 years from the date on which the settlement is approved. The prohibition does not apply to schedule member injuries for less than 200 weeks. The statute prohibits an employee who is permanently totally disabled from settling the employee's right to future medical benefits.

***Proposed Amendatory Change***

The amendment deletes *TCA* §50-6-206(a)(2)(A), (B), (C) and (D) - the entire section enacted in 2004. The amendment states employees are entitled to relinquish their right to future medical treatment if the Department or Court finds it is in the best interest of all parties to do so. The only exception is employees who are determined to be permanently totally disabled and the employer had never contested compensability.

***Practical Effect***

The amendment returns the law to the way it existed prior to the 2004 Reform Act and permits an employer or insurer to settle the entire claim by paying a monetary amount to the employee in return for his giving up the right to lifetime medical benefits for the work-related injury. For claims that were settled before the 2004 Reform Act, the Department or Court that approved a settlement had to determine the settlement (disability and future medical settlement) was in the best interest of the employee. The amendatory language requires the Court or Department to find the settlement of medical benefits is in the best interest of ALL parties.

With regard to employees who are permanently totally disabled, the amendment permits these workers to accept money in lieu of lifetime medical benefits IF the employer had claimed the injury was not work-related (i.e., the employer contested compensability of the injury). Therefore, if an employer contested an injury as not work-related and subsequently decided to settle the claim by paying permanent total disability benefits - the employer could pay a small sum for medical expenses and get the employee to settle on this basis. Under federal law - this could pose real problems for Medicare Set Aside liability for am employee who is so injured they can never work again if one assumes this type injury would require additional and ongoing medical treatment.

**AMENDED SB 1797 by Southerland / HB 2129 by Fitzhugh, cont.**

***COMMENTS OF ADVISORY COUNCIL MEMBERS:***

**Note:** The discussion of this issue by the members of the Advisory Council was robust and lengthy. Thus, the comments of the members are not divided by category, but are presented in the time frame as the comments were made.

Mr. Farmer stated he believes this amendment opens the Department of Labor/WFD to an extremely complex issue in advising an unrepresented worker - the Medicare Set Aside issue. This issue could dramatically impact that employee's right to medical treatment of any kind in the event medical coverage under the workers' compensation statute is terminated for any amount of money. Mr. Farmer said he knows the Department is not prepared to address the issue of Medicare Set Aside because no one is in the position to do that - all attorneys are having to get outside services to evaluate the complex issue of Medicare Set Aside. More importantly, the 2004 Reform Act had as a primary objective of allowing workers to move through the system without being bogged down by lawyers. That has produced a very significant increase in the number of unrepresented workers. With these workers being presented with a few hundred dollars to terminate medical coverage that they don't even understand - he personally feels this is morally corrupt. He does not believe the business people think there is a positive aspect to this bill. He believes the bill is irresponsible as far as the state government and the federal government are concerned and it is motivated primarily and essentially by greed. There are situations on doubtful and disputed claims where it is convenient to be able to close future medicals but the inconvenience of waiting three years to be able to close future medicals does not outweigh the potential harm that the bill provides to the worker.

Ms. Boyte stated she is personally unaware of any situation since the 2004 Act where a case did not settle that would have settled had the parties been able settle medicals simply because of the new law - it became a non-issue. Mr. Farmer said the specialists could give many examples of the issue being raised as a problem - it is constantly discussed in the Knoxville office by defense lawyers and adjusters that they need the ability to close medicals. He said unrepresented workers are not in a position to evaluate that decision and they are running the risk that they will not be eligible for Medicare benefits if they terminate medical care under workers' compensation. This is a very sophisticated issue and one that is being picked up and run with by Medicare and Health and Human Services.

Mr. Sims noted this is probably an issue the Administration should be pondering - as it reverses a key feature of the Governor's workers' compensation reform proposals. He said he recalls discussions before committees as a feature the Administration felt was a significant protection for workers.

**AMENDED SB 1797 by Southerland / HB 2129 by Fitzhugh, cont.**

***COMMENTS OF ADVISORY COUNCIL MEMBERS, continued:***

Ms. Head agreed the three year provision regarding the settling of medicals was a major issue in the reforms. The Department feels the issue of settling medicals has made an impact in the Benefit Review Program and is a regular situation raised in the program. Ms. Teresa Bullington, Director of the Benefit Review Program, agreed the section of the statute that prevents closing of future medicals for claims over the statutory monetary threshold for those cases in which the amount in controversy could be $200,000 if the case is compensable or $0 if the claim is not compensable has been an impediment to compromising and settling disputed claims. In the past the parties might compromise and settle this type of claim for $75,000 but most carriers will not want to compromise and settle a disputed claim without the ability to also settle medical benefits.

Ms. Boyte stated she believes the biggest impediment to settling claims is the provision of the law that sets a monetary cap of 10 times the minimum weekly compensation rate for the settlement of disputed claims and suggests deleting *TCA* §50-6-206(b) - in addition to or in lieu of deleting *TCA* §50-6-206(a)(2). Mr. Farmer agreed the monetary cap on disputed claims is an inhibitor on the settlement of the disputed claims.

Mr. Sims suggested if there has been an inadvertent consequence of leaving the medicals open for three years that the Department is aware of, it is incumbent on the Department review the issue and to bring a solution to what appears to be a rather complicated issue. If this is a problem, he stated he would appreciate the Department's advice on what the most appropriate solution is, keeping in mind open medicals is a significant issue and in terms of the Medicare Set Aside issues.

Mr. Farmer suggested the priorities of defense attorneys, the priorities of the Department and his priorities may be different. He stated his top priority is not to see every case resolved by settlement - his top priority is to see every worker fairly compensated.

Mr. Lee stated when the Reform Act was being negotiated, the provision was initially five years for non-settlement of medicals and a compromise was struck at three years. He feels the three years was reasonable then and it is still reasonable. Mr. Lee said he doesn't know many workers who have been injured and off work who wouldn't jump at a chance to settle a claim for medicals for 5, 10 or 15 thousand dollars when their income has been interrupted. He thinks the three years should be kept to see if the worker is going to continue to need future medical treatment and feels it would be egregious to take that option away from the employee.

**AMENDED SB 1043 by Finney, L. / HB 595 by Turner, M.**

***Present Law***

*TCA* §50-6-121 provides the chair and co-chair of the special joint legislative committee on workers' compensation (*TCA* §50-6-130) serve as ex officio, nonvoting members of the Workers' Compensation Advisory Council.

***Proposed Change - Original Bill***

SB 1043 / HB 595 deletes the chair and co-chair as ex officio, non voting members of the Advisory Council and substitutes the chair or co-chair of the standing committees of the House and Senate as ex officio, nonvoting members of the Council.

***Practical Effect - Original Bill***

The bill places the "chair or co-chair" (Rep. Turner has indicated he will amend the bill to say chair and vice-chair) of the House Consumer and Employee Affairs Committee and the Senate Commerce, Labor and Agriculture as ex officio, nonvoting members of the Council in place of the chair and co-chair of the Joint Committee.

***Proposed Amendatory Change***

The amendment is a technical correction. It deletes the word "co-chair" and substitutes the term "vice-chair", which is the correct committee designation.

***COMMENTS OF ADVISORY COUNCIL MEMBERS:***

The Council defers to the General Assembly as to the composition of the membership of the Advisory Council. The Council notes the amendment to SB322(Haynes)/HB1818(Hackworth) continues the Joint Committee and the chair and vice-chair of the Joint Committee are ex officio members of the Council.

**AMENDED SB 1805 by Tracey / HB 1569 by Curtiss**

***Present Law***

*TCA* §50-6-204(d)(5), enacted in 2004, provides when a dispute as to the degree of medical impairment exists, either party may request an independent medical examiner from a registry established by the Commissioner of Labor/WFD.

Section 3 of the original bill deletes the current statute regarding the independent medical examiners registry and re-drafts the language by outlining in specific terms the conditions under which a party can request an examiner from the registry - making it clear two competing impairment ratings are not necessary to access the registry program.

***Proposed Amendatory Change***

The amendment removes Section 3 from the original bill.

***Practical Effect***

With the removal of Section 3 of the bill, the Medical Impairment Rating Registry program will continue as currently administered pursuant to the rules and regulations adopted by the Department of Labor and Workforce Development.

***COMMENTS OF ADVISORY COUNCIL MEMBERS:***

**ATTORNEY REPRESENTATIVES**

Ms. Kitty Boyte — Ms. Boyte stated she does not understand why Section 3 is being deleted as the changes being made by it to the MIRR program was one of the smartest bills being proposed. She said (as a friend of system) the original intent of the MIRR program was an effort to get unrepresented employees through the system at their greatest advantage. If they were unhappy with their impairment rating they had an opportunity to go to the Department and have the employer pay for an independent medical evaluation instead of having to hire an attorney and the lawyer sending them out to a doctor for a higher rating. This MIRR rating was to be the trump card and, therefore, the employee could go to the benefit review conference unrepresented and not

**AMENDED SB 1805 by Tracey / HB 1569 by Curtiss, cont.**

***COMMENTS OF ADVISORY COUNCIL MEMBERS,cont.***

worry about a very low rating from the treating doctor. Dr "MIRR" was going to be the correct rating and the parties could decide what settlement the employee would receive. The way the rules were promulgated completely deleted that particular accomplishment of the whole program. Now, you have to have two ratings before you can access the program. Neither of the attorneys are going to want to access the MIRR program except in very limited circumstances because they do not want the "trump card" of the MIRR doctor - they would rather argue why their particular doctor's rating is the correct one. The original bill (Section 3) returned to the original purpose of why the MIRR program was enacted and she is shocked it is being deleted.

Mr. Tony Farmer — Mr. Farmer agreed the original Section 3 of the bill addresses the original intent of the 2004 Reform Act to prevent "dueling doctors". As implemented, you cannot access the program without two doctor ratings. He believes the entire system of workers' compensation in Tennessee both for the employer and the employee would be more efficient and effective without the Medical Impairment Registry Program and it would be easier on the Department.